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# Pediatrics for Parents

*The newsletter for people who care for children*

Richard J. Sagall, MD, Editor

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# Secondhand Smoke Dangers

Sudden Infant Death Syndrome (SIDS), colic, middle ear infections, worsening of asthma symptoms, respiratory problems – this is just a partial list of children's medical problems associated with secondhand smoke exposure. Despite all the known adverse health effects, 40% of American children are routinely exposed to secondhand tobacco smoke in their own homes. Adverse effects on cognitive skills should also be added to the list.

In a study that was published in 2005, doctors at the Cincinnati Children's Environmental Health Center at the Cincinnati Children's Hospital Medical Center found that the higher a child's urine cotinine level (a breakdown product of nicotine and an indicator of tobacco smoke exposure that's excreted in the urine), the lower the performance on tests of math, reading, and visual-spatial skills. Data from more than four thousand nationally represented children ages 6-16 was used for the study, The decreases were seen even at low cotinine levels. The lower test scores correspond to an IQ decrease of two to five points.

*Environmental Health Perspectives*, 01/05

# Infant Abuse

The first national study of infant abuse and neglect found a "distressing" total of 91,278 cases in 2006. Nearly one-third involved babies a week old or younger. The study looked only at abuse in children one year old and younger.

According to Ileana Arias, PhD, director of the CDC's National Center for Injury Prevention and Control, "When we got the numbers – I wouldn't say we were surprised – but we were certainly distressed."

From October 2005 through September 2006, child protection services investigated 3.6 million cases of possible neglect or abuse of children 18 years old and younger. Of these cases, 91,278 involved substantiated maltreatment (neglect or abuse) of children under one year – a rate of 25 per 1,000 children (or 2.5%).

- 35,455 (38.8%) were younger than one month old
- 29,811 (32.7%) were younger than one week old
- 499 (0.5%) children under one year of age died

The study didn't look at the specific types of abuse. Many of the abuse cases of children one week or younger may have been the result of maternal drug abuse testing. Prenatal exposure to drugs is considered a type of child neglect.

*Morbidity and Mortality Weekly Report*, 4/08

# SIDS –Lowering the Risk

*By Katherine Brazzale, MD*

Perhaps the greatest fear for any new parent is that of SIDS (Sudden Infant Death Syndrome), probably because no exact cause has been identified, and the ability to prevent it remains a mystery. The good news is that as more research has been done to clarify the SIDS phenomenon, it has become easier to identify infants and families at greatest risk and advise parents on steps they can take to minimize it.

Though the incidence of SIDS has declined sharply in recent decades, SIDS is the leading cause of post-neonatal mortality (death between one month and one year of age) and causes some 2,300 deaths per year in the United States. The average age of death attributed to SIDS is 11 weeks, with peak incidence between two and four months of age. The accepted definition of SIDS is "sudden death of an infant younger than one year that remains unexplained after a thorough postmortem investigation, including a complete autopsy, examination of the death scene, and review of the clinical history." SIDS is therefore a diagnosis of exclusion.

## Identifying Vulnerable Infants

In looking to identify infants most at risk, and thereby provide closer monitoring, researchers have identified several factors – some of which are modifiable – that hopefully will provide some reassurance to parents. Unfortunately, some of the factors are not modifiable.

Pregnancy-associated risk factors indicating which babies are more vulnerable to SIDS include placenta previa, abruptio placentae, premature rupture of membranes, and small for gestational age neonates. Obviously many factors may contribute to babies being born small for gestational age. Other maternally-related factors include mothers being in their teens, poor prenatal care, giving birth preterm. and the baby being of a low birth weight. Demographic risk factors also include the mother being of a lower educational and socioeconomic level and being a single parent. Within both the United States and the United Kingdom, most SIDS deaths today occur in disadvantaged families.

Perhaps the most important of the modifiable risk factors are maternal smoking and recreational drug use. Maternal smoking during and after pregnancy has long been known to be a very strong risk factor for SIDS, and the more the mother smokes, the greater the risk to the infant. Indeed, any smoking around the infant can increase the risk of SIDS by almost two-thirds. In addition, illegal drug use (cannabis and opiates in particular) is a significant risk factor even after accounting for tobacco smoking.

## The Sleep Environment

The sleep environment is also a major factor in determining risk of SIDS, and it is also one that can be easily modified. This was proven when the back-to-sleep campaign was initiated in 1994. With the widespread acceptance of this plan, the risk of SIDS in the United States fell more than 50% from 1992 to 2002. Risk factors studied over the years include sleep position, sleep surface, clothing, bedding, room temperature, and whether or not the infant shared the bed with its parents. As a direct result of this research, the American Academy of Pediatrics (AAP) has developed a set of recommendations to reduce SIDS risk.

Particular interest has centered on resultant low oxygen blood saturations, and the possibility that these infants may have an impaired ability to arouse from sleep. Even healthy infants, in general, have an immature response to low oxygen concentrations when compared with adults, so the ability to wake up by themselves is an important defense mechanism to protect them from prolonged low oxygenation. It is thought that infants are at greater risk for SIDS if their ability to self-arouse from sleep is underdeveloped.

Results of studies in sleeping supine (face up) are unequivocal. Infants are less likely to develop SIDS if they sleep on their backs. They are more easily aroused in this position and can thus respond more readily to low oxygen concentrations in their blood. However, when the back-to-sleep campaign was first recommended, some doctors were concerned about the risks of choking on vomit, aspiration pneumonia, gastroesophageal reflux, and plagiocephaly (flattening of the head due to sleeping in the same position repeatedly). In light of the potential for developing plagiocephaly in infants who always sleep in the supine position, parents need to understand an infant's need for "tummy time" and should place the infant on his or her stomach during wake time when someone is watching. Tummy time promotes development of neck, shoulder, and head muscles. In addition, the AAP recommends moving the infant's head occasionally from one side to another during sleep.

Controversy and strong emotion have surrounded the issue of parents sharing a bed with their infants. Bed sharing (also called "co-sleeping" and "family bed") has

become increasingly common, partly because it can facilitate breastfeeding and promote mother-infant bonding. In some studies, the risk of SIDS with bed sharing is higher only in mothers who smoke and in very young infants (11-16 weeks). The chance of blankets and pillows covering the baby's face is also greater in the parents' bed, and bed sharing is riskier if the mother is overtired or has used medications (or illegal substances) that promote drowsiness. The AAP recommends that an infant can be breastfed in the parents' bed but then should be returned to his or her own crib, preferably in the parents' room, which also reduces risk. Medical professionals also agree that infants should never sleep with parents or other children on a sofa. This practice carries extremely high risk as the cushioning and seat pads on a sofa are often excessive and can sometimes shift during sleep smothering the baby. Sleeping toddlers and children can move excessively without being aware of their surroundings. Consequently, if they end up sharing this unsuitable substitute for a bed with an already vulnerable infant then the likelihood of accidental suffocation is extremely high.

### Pacifier Use

Although the biological mechanism is unknown, recent studies strongly suggest that pacifier use, particularly when the infant is placed for sleep, lowers the risk of SIDS. Arguments that have been made against using pacifiers include a reduction in breastfeeding, dental malocclusions, and an increased risk of otitis media and oral yeast infections. The controversy continues, but the AAP finds the reduced risk of SIDS in studies of pacifier use to be compelling and recommends that a pacifier can be used, with certain restrictions. They suggest that pacifiers should be discontinued at one year of age, used during nap or bedtime, kept clean, and, for breastfeeding infants, not used until breastfeeding is established at about one month.

### Immunizations

Immunization has been a controversial topic for a number of years for various reasons, but recent studies continue to show no association between SIDS and diphtheria-pertussis-tetanus (DPT) immunization.

### Home Monitors

For worried parents, the idea of home monitors has intuitive appeal. Unfortunately, studies have found that apneic events (pauses in breathing) are so common in all post neonatal infants that no surveillance system is sensitive or specific enough to be useful as a preventive measure for SIDS. The AAP position is that monitors might be appropriate for infants who have had an apparent life-threatening event (ALTE), defined as an event that is frightening to the caregiver but does not lead to collapse or death. No evidence, however, shows that home electronic surveillance reduces the risk of SIDS.

### Additional Sources of Information

The American Academy of Pediatrics
http://www.aap.org/healthtopics/sleep.cfm
The National Institute of Child Health and Human Developmentt
http://www.nichd.nih.gov/sids
The National SIDS/Infant Death Resource Centre
http://www.sidscentre.org

### Conclusion

In light of extensive recent research, we now know of a number of measures that parents can take to minimize the risk of SIDS for any infant. These include smoking cessation, abstinence from recreational drug use, having the infant sleep in its back, and doing one's best to optimize the health and care of the mother throughout her pregnancy. Unfortunately some factors remain unmodifiable. Better awareness of such factors, however, will hopefully lead to earlier identification of infants at greater risk, and reduction of this risk by better education of childcare givers.

*Katherine Brazzale, MD, is the chief resident in family and community medicine at Shands University of Florida. She did her first degree and medical training all at University College London, in the UK, and then worked as a doctor there, for one year, before coming to the U.S. three years ago.*

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# Salt, Soda, and Obesity

The more salt in a child's diet, the more soda he drinks and the greater his chances of becoming obese. That's the finding from a study in Great Britain.

The data collected from 1,600 children ages four to eighteen found those who ate a lower-salt diet drank less fluid and especially less sweetened soft drinks. The researchers calculated that by decreasing daily salt intake by 1 gram per day would lessen the child's sugar-sweetened soft drink consumption by 27 grams.

According to Feng J. He, MD, the lead researcher, "If children aged four to eighteen years cut their salt intake by half – an average reduction of three grams per day – there would be a decrease of approximately two sugar-sweetened soft drinks per week per child, so each child would decrease caloric intake by almost 250 calories per week."

*Hypertension*, 03/08

# Long-Term Effects of Dieting Articles on Adolescents

*By Vikki Sloviter*

Eating disorders rarely exist in impoverished nations. Countries and cultures where food is scarce do not have noticeable incidents of anorexia or bulimia. Yet here in the United States, 0.5-1.0% of young women are diagnosed with anorexia nervosa, and 6-20% of those with clinical anorexia die from it. Though many of us know of such statistics, how is it that body image continues to plague our youth, particularly our young girls? Adolescents know that fashion magazines such as *Elle* and *Vogue* contribute to unhealthy body images because they know that the models within those pages represent only 1% of the American female population and are airbrushed to appear even more flawless. But such knowledge does not seem to deter them from reading such magazines or aspiring to be model-thin.

Patricia van den Berg, PhD and her colleagues from the School of Public Health at University of Minnesota set out to determine exactly what the effect of reading dieting advice in magazines had on adolescents. Specifically, they conducted a longitudinal study to evaluate the association of the frequency of reading magazines containing dieting and/or weight loss articles with weight-control behaviors and psychological outcomes five years later. Coined Project EAT, the study used data from 2,516 Minnesota junior high and high school students in grades 7-12 from 1999 (time 1) and 2004 (time 2).

Jennifer Utter, MPH and her colleagues published a similar study in the January 2003 issue of the *Journal of Adolescent Medicine* that examined the relationship between the sociodemographic characteristics of adolescents who read magazine articles on dieting and weight loss and their psychosocial well being and weight control behaviors. Though they found a relationship, indeed "[d]ieting-related magazine exposure was associated with indicators of psychosocial distress and unhealthy dieting," the nature of the study was unable to determine if reading the magazine articles clearly caused the adolescents to adopt unhealthy attitudes toward body image or if adolescents who were inclined to have an unhealthy body image sought out such magazine articles. Van den Berg's recent study aimed to answer the question of the long-term effect of magazine reading on certain eating behaviors and attitudes.

The study results were not too surprising. Forty-four percent of the females reported reading dieting articles "frequently," compared to only 14% of the males. Whereas white and Asian female respondents were more likely to read dieting articles, white and Native American males were less likely to read them. Among the females, girls in the lowest socioeconomic category were less likely to frequently read dieting articles than girls in the other socioeconomic categories. However, the results showed that the higher socioeconomic level a male respondent came from, the less likely he was to frequently read the articles.

More importantly, the study results confirmed what the researchers had guessed: that the more often an adolescent reads diet or weight-oriented magazine articles, the more likely he or she will engage in unhealthy weight-control behaviors. After controlling for certain variables, the researchers found that, compared to girls who never read diet or weight loss-oriented articles, girls who "often" read them were just as likely to engage in healthy weight-control behaviors, twice as likely to engage in unhealthy weight-control behaviors or binging, and three times as likely to engage in extreme weight-control behaviors. And, when compared to other males who never read diet and weight-oriented articles, males who "often" read weight-related articles were one and a half times more likely to engage in healthy weight-control behaviors, as likely to engage in unhealthy weight-control behaviors, slightly less likely to engage in extreme weight-control behaviors, but three times more likely engage in binging. Interestingly, the results showed that there was no increased measurement of depression, self-esteem or body satisfaction associated with frequency of reading diet and weight-oriented articles.

So what do these results mean? Past research on this subject had shown short-term negative effects of reading diet and weight-oriented articles on weight-control behavior and body image, but this study concluded that there is, as well, a long-term effect. Five years of frequently reading such articles can have a negative impact on an adolescent's weight-control behaviors. The researchers concluded that, based on the study, there continues to be a need to limit the exposure to such potentially harmful media content. They suggested three media interventions: 1) mothers "stop buying these magazines for themselves so that they are not inadvertently exposing their daughters to the dieting/weight loss messages and thin ideal images in these magazines," 2) enhance adolescents' media literacy

skills, and 3) healthcare providers remove "appearance, diet, and weight loss-oriented magazines from waiting areas and examination rooms, so as not to reinforce potentially harmful social norms and messages within health promotion settings."

Recognizing the media's role in adolescent behavior and practices is not new. In 1999, the American Academy of Pediatrics (AAP) introduced "Media Matters," a campaign to "media-educate" families (parents, children and adolescents alike). Though their approach incorporated all types of media, the AAP's message was clear: parents and healthcare providers will have to be responsible for educating their children on the media because the media isn't taking responsibility. The AAP recommended that parents take steps to provide positive and educational offerings, and keep the lines of communication open with their children.

It is never too early to talk with your child about what she reads. Just as you might discuss a book's plot or character development with your fifth grader, you can talk about the messages conveyed in fashion magazines and other commercial media that suggest unrealistic or unhealthy ideals. Parents need to teach their children to engage in healthy weight-control behaviors, such as eating a proper diet and exercising regularly. If our children, especially our daughters, see us buying and reading the latest issue of *Cosmopolitan*, then we're sending the wrong message.

*Vikki Sloviter received her BA in History of Science and Medicine from Yale University. She lives in Bucks County, Pennsylvania with her husband and three young children. She also proofreads, copy edits, researches and writes for Pediatrics for Parents and NeedyMeds.com.*

# Newborn Vision

## By Aimee Alderman-Oler, MA

When your newborn looks at you, she may sometimes appear cross eyed, or perhaps one eye might roll in, seeming to look at her nose. This is, in part, because the newborn does not focus well. As a matter of fact, at birth, vision is the least developed of the five senses. Although perfectly normal, her seemingly errant eye(s) can be disconcerting. To strengthen her eyes, parents can do a simple exercise with their newborn a couple of times a day. This will help the baby work toward getting more organized when looking at things, and make her eyes less jerky and jumpy and more coordinated and smooth.

### Tracking Exercise

Tracking is an eye exercise that can provide appropriate practice focusing both eyes on a single object. Some examples of easy, enjoyable and engaging objects to track are:

- a mirror
- black and white simple patterns such as a checkerboard pattern, bulls eye or stripes, which can easily be drawn with a black marker on white paper
- a single simple high-contrast picture in a bright color, such as a red bird on a white background
- a vivid picture of a baby face, such as one cut from the cover of a parenting magazine

Make sure there is enough light for baby to see the object clearly. Hold the object 8-15 inches from your child's face. First let your newborn study the object, and then move the object smoothly and slowly side to side to encourage smooth tracking. Tracking practice helps your baby to move both eyes together.

A parent's own face is the most visually stimulating object for a newborn. Because she sees best at the distance measured between her and a parent's face in feeding position, and because she has a strong attraction to her parent's face, it is ideal for tracking. When your newborn is quiet and alert and gazing intently into your face, slowly move your face from side to side. Your child will follow with her eyes, improving the coordination of the small muscles that control eye movement.

These simple exercises will provide practice focusing the eyes and moving the eyes together, but watch for signs that indicate when baby has had enough stimulation. Your baby may turn away, begin to cry, or raise her hand to cover her eyes. Then it's time for a break!

### What comes next?

Tracking is the foundation block for skills to come. Very soon, baby will have better visual ability to notice details, making vision an important source of information. By six months, babies see in color. They have depth perception. Walking slowly around a large object will help your child create a 3D image of it in her mind. Babies may stare for longer periods of time, examining an object for up to one minute. At this age, they can see between four and 11 feet. To find out how far your baby can see at this age, slowly walk away when she is looking at you and notice when she loses focus. By one year, your child will have almost adult vision!

*Aimee Alderman-Oler is a certified parent educator living and working in Kansas City, MO.*

# Children in Hospitals

*By John E. Monaco, MD*

## Head Trauma: An Unusual Presentation

An eight-month-old little boy was brought to a local pediatrician's office because of cough. It seemed like a fairly straight-forward, run-of-the-mill complaint, especially in the midst of cold and flu season. The pediatrician asked the usual questions pertinent to the complaint. Was there fever? Was there difficulty breathing, wheezing or mucus production? How were the child's appetite and activity level? It was the answer to this last question that gave him pause. The mother stated that the child had been sleepier than usual, and that he had thrown up a few times, especially that morning. Also his appetite had not been up to its usual vigorous standards.

These symptoms could still be present with respiratory infection, the pediatrician thought, however the sleepiness and the vomiting did seem to be out of proportion with some of the child's other symptoms. Sleepiness and vomiting, he thought to himself, are often signs of something wrong with the nervous system.

After questioning the mother further and getting no more insight into the child's illness, he then proceeded with his physical exam. Since the child was quiet – asleep actually – in his mom's arms, the pediatrician decided to listen to the heart and lungs first, a task made much more difficult with a screaming, combative infant. The lungs were completely clear, and the heart sounded normal. It was now time for the ears and throat. When he placed his hands on the child's head to position him for the ear exam, he felt it: a boggy area on the side of the child's skull. The child jumped a little when the doctor ran his fingers over it, as if the bump were painful.

The pediatrician asked the child's mother what the bump was and if the child had injured himself in any way. As a matter of fact, she remembered, her son had been playing in the bathroom the day before, while she was in there with him. She said that he had been crawling around on the floor and at one point attempted to climb up on the bathtub and fell on the floor, hitting his head. She hadn't thought anything of it at the time since he cried immediately and didn't seem to be affected by the fall, other than typical temporary discontent.

The pediatrician thought differently and sent the child to our hospital for a stat CT scan of the head. One of my associates was asked to assist with the procedure since most kids this age require some sort of sedation in order to achieve a good quality study. This patient did not require sedation, however, because he was already quite sleepy, and thus inappropriately cooperative. His unusual sleepiness was explained by the findings of the CT scan.

Surprisingly, this child was found to have sustained a subdural hematoma – a bleed under the skull – within the brain area that measured three by seven centimeters. The large blood collection was pressing on the temporal lobe and causing the midline of the brain to shift away from the injured area. These were all very serious signs and required immediate attention by a neurosurgeon.

Within hours this little boy was in the operating room where the neurosurgeon evacuated the hematoma. The underlying brain was found to be completely healthy and normal and soon after surgery, this otherwise-healthy eight-month-old was awake and playing with toys in his crib.

This case was soon the talk of the doctor's lounge. It was humbling and frightening for those of us who take care of children to see how subtly such a serious injury could present. It was also a credit to the child's pediatrician, who, despite the simplicity and ordinariness of the presenting complaint (cough), conducted a thorough history and physical exam that eventually led to an accurate diagnosis and that ultimately saved a child's life.

*John E. Monaco, MD, is board certified in both pediatrics and pediatric critical care. His new book,* Moondance to Eternity, *is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.*

# "Baby Doc" Eden Explains

*By Alvin N. Eden, MD*

## Breastfeeding

There have been considerable advances in recent years in the scientific knowledge of the benefits of breastfeeding, both for the baby and for the mother. The ideal way to nourish a baby is to breastfeed. Human milk has been shown to be ideally suited to the infant's nutritional and emotional needs. Further, there is strong evidence that breast milk contains antibodies that protect the baby against many viral and bacterial infections. This decreases the incidence and/or the severity of a wide range of infectious diseases, including meningitis, diarrhea, pneumonia and urinary tract infections. In addition, infant morality rates after one month of age are reduced by 21% in breastfed infants.

There are many other health advantages for your baby if you breastfeed. Among the most important are the following:

1. Breastfed babies are better able to handle cholesterol later on in life.
2. Breastfeeding reduces the number of middle ear infections your baby will develop.
3. Breastmilk protects against certain forms of cancer, such as lymphoma and leukemia.
4. Many studies have shown that breastfeeding increases your baby's I.Q.
5. Breastfeeding protects against overweight and obesity.

I am often asked how long a baby should be breastfed to achieve the maximum benefits. There is no specific length of time. The best answer I can give is the longer the better. Even one month of breastfeeding is better than no breastfeeding at all.

Some investigations measuring the I.Q. increase associated with breastfeeding suggest that at least three months is needed. Similarly, other studies have shown that in order to obtain the benefits of immunity against certain illnesses a minimum of three months of breastfeeding is required. But as far as I am concerned, six months is better than three months and twelve months is even better.

This leads me to another question. Can breastfeeding be continued for too long? Or is it ok to continue breastfeeding after twelve months? It certainly is. Many mothers are still breastfeeding at their toddler's second or even third birthday party. As long as both mother and child are happy with the feeding, there is no medical reason to stop.

There are very few contraindications to breastfeeding your baby. Mothers in the U.S. who are HIV positive are advised not to breastfeed. Breastfeeding is also contraindicated for mothers with active tuberculosis, those receiving antibodies or chemotherapy agents, or are using drugs of abuse ("street drugs"). Antibiotics are not a contraindication to breastfeed.

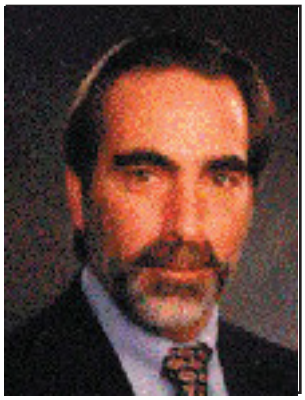
It is important to remember that although breast milk is the healthiest way to feed your baby, it still does not supply all your baby's nutritional needs. There is insufficient iron and vitamin D in breast milk and so The Committee on Nutrition of the American Academy of Pediatrics recommends that supplemental vitamin D and iron be given to exclusively breastfed babies starting between two to four months of age. Please consult your baby's pediatrician about this recommendation.

The health advantages for the breastfeeding mother are less known than those for the baby. But, here are a few known advantages:

1. Decreases post-partum bleeding and more rapid involution of the uterus
2. Reduces the chances of developing post-partum depression
3. Decreases the risk of obesity and type 2 diabetes mellitus
4. Decreases the risk of breast and ovarian cancer
5. Decreases the risk of osteoporosis and hip fracture in the post-menopausal period
6. Allows mother to get back into shape more quickly with earlier return to pre-pregnancy weight

More mothers choose to breastfeed now than did twenty or thirty years ago. In fact, in 2007 the Centers for Disease Control reported that 73.8% of all U.S. babies born in 2004 had been breastfed at some point.

***Continued on page 9***



# Perspectives on Parenting

*By Michael K. Meyerhoff, EdD*

## Promoting Autonomy in Toddlerhood

During the first months of life, the key psychological issue for infants involves the development of a sense of trust. The helpless newborn must learn that he can count on his fellow human beings, particularly his parents, to care for him during this period when he is completely unable to care for himself. And as long as he receives the kind of consistent and competent nurturing services that most mothers and fathers provide, developing this solid foundation for all future interpersonal relationships ordinarily proceeds without problem.

However, as the child moves into toddlerhood, his psychological health may very well become jeopardized. The key issue at this point is autonomy. Now that he is a toddler, he can start doing things for himself. He can move around on his own, he can start feeding himself, and he can start dressing himself.

If he is encouraged to do so and praised for doing so, he develops a strong sense of independence that will enable him to become a capable and self-sufficient citizen of the world in the years to come. But regrettably, a lot of mothers and fathers do not do an entirely admirable job of helping their child through this stage.

Once a child starts to crawl around on his own, he enters a very exciting time of life. He can explore new areas, investigate new things, and learn all sorts of new stuff as he wanders about. Unfortunately, he also enters a very dangerous time of life. He can fall down a flight of stairs and he can find poisonous substances under the sink. And not only are there things that can harm him, but there are many things that he can harm. He can knock over delicate glass vases or pull out all the wires on an expensive stereo system.

So, if you are a loving and conscientious parent, how do you handle this situation? Well, mothers and fathers tend to go in one of two directions. Some safety proof their home, making as much of it as possible accessible and hazard-free for their adventurous little one. They then let him roam about at will. Others decide to restrict their child to a playpen or a gated area for much of the day. They toss in a lot of toys to keep him entertained and occupied, then let him roam about only when they are available to supervise.

Both approaches seem highly responsible and eminently sensible. However, if you understand how critically important it is for a toddler to develop a sense of autonomy, it is clear that there is only one way to go. In order for their child to be psychologically as well as physically healthy, parents really have no choice but to take the safety-proofing route.

Let's say a toddler's parents decide to restrict him unless they are present to protect both him and their household possessions. When they set him free, what happens? The child eagerly roams around, and his parents follow close behind shouting, "No! Stop! Don't touch that! No! Don't go there! No!" What lesson does that teach the toddler? He learns that when he exercises his new abilities, the people he loves the most don't like it and get upset. Instead of developing a strong sense of independence, he instead starts to feel shameful and doubtful about going off and doing anything on his own.

Although taking the safety-proofing approach obviously is less convenient and more risky, it does not have to be onerously so. The toddler does not have to be given access to every area of the house. Various rooms can be designated as off limits and be kept either gated or locked. And even if the parents do a thorough job of safety proofing, there will be plenty of times in the course of the day when they will still caution, "No! Stop! "Don't touch!" It is merely necessary that the preponderance of the child's experiences be positive and that he generally gets good vibes from those he loves when he goes off on his own.

Another aspect of promoting autonomy during toddlerhood where a lot of modern mothers and fathers could stand considerable improvement concerns self-help skills. As noted earlier, this is the time of life when the child starts to learn how to feed and dress himself. And these skills require a measure of patience on his parents' part. Regrettably, many families today seem to be on an incredibly hectic schedule. Everyone is busy and in a rush. Consequently, the little one figuring out how

to take care of himself becomes more of an imposition than someone to be encouraged and praised.

Let's say the family sits down to breakfast. The toddler grabs a spoon and attempts to scoop some cereal into his mouth without adult assistance. His parents look over and exclaim, "Wow! He's trying to feed himself!" But then they look at the clock and bemoan, "We really don't have time for this." They then proceed to take the spoon away from their little one and hurriedly shovel the remainder of the oatmeal into his mouth themselves.

Or let's say everyone is getting ready to go out. The parents put a jacket on their toddler, and he grabs the zipper and attempts to fasten his clothing by himself. His parents look over and exclaim, "Wow! He's trying to dress himself!" But then they look at the clock again and bemoan once more, "We really don't have time for this." They then proceed to take over the task and quickly zip up the jacket themselves. The result of these actions is that the parents stay on schedule, but their child develops the distinct impression that when he chooses to exercise his new abilities, it gets in the way and upsets those he loves, so it is better to just sit there and continue letting others do things for him.

Furthermore, mothers and fathers need to be aware that promoting autonomy in toddlerhood requires understanding as well as patience. Let's say that the family is having breakfast, and the child decides he is going to pour his own milk. As he picks up the bottle, he knocks over his glass, and milk gets spilled all over the table. What do the parents do? They start screaming at him, "What are you doing! Look at the mess you made! Don't ever do that again!"

Later that same day, the mother and father invite a guest over for dinner. As everyone is enjoying the meal, the guest decides to refill his wine glass. As he picks up the bottle, he knocks over his glass, and wine spills all over the table. What do the parents do? They smile at him and say, "That's okay. Accidents happen. Here, let's try again." Why is it that we are inclined to be so much more understanding with a guest than with our own child?

Obviously, promoting autonomy in toddlerhood is not easy and it does invite a fair amount of inconvenience, some unpleasant messes, a few annoying delays, and the arrival of several gray hairs. But loving a child means learning to let him go. With some planning, effort, patience and understanding, parents can ensure that their child will grow up to be a psychologically healthy individual who is proud of himself and of whom they can be proud. That is a tremendous payoff for the investment.

*Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicntrinc@aol.com.*

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***Breastfeeding – continued from page 7***

But there are still too many women who decide not to breastfeed. The message contained in this article about the tremendous advantages of breastfeeding both for the baby and mother has not been getting through to enough people. Many health care professionals simply don't take the time to educate mothers-to-be about the importance of breastfeeding or have not themselves been taught enough about the subject to be effective in convincing mothers to make every effort to successfully breastfeed.

What is equally disturbing is that too many mothers that leave the hospital breastfeeding their newborn stop too soon, often after the first week or two. In 2007 only 30.5% of U.S. babies born in 2004 were still exclusively breastfed at three months. This rate drops to 11.3% for babies exclusively breastfed at six months. And, even though the American Academy of Pediatrics recommends that babies breastfeed for at least one year, only 20.9% of U.S. babies born in 2004 breastfed a year later.

In my experience, one of the main reasons American mothers stop breastfeeding is that there are increasingly more mothers who work outside the home and believe that once they go back to work, the breastfeeding must stop. Wrong! The supply of breast milk is determined by how often the baby is put on the breast for feeding. If suckled less often, the milk, supply decreases. Therefore, there is absolutely no reason to stop breastfeeding after going back to work. Your baby will easily learn to drink either stored breast milk or formula from a bottle while you are away and will happily breastfeed without difficulty when you are back home.

*Dr. Eden is the chairman of the department of pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a clinical professor of pediatrics, Weill Cornell Medical Center, New York, NY. His latest book,* Positive Parenting, *is now available.*

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# Children's Emergencies

*By Martin Belson, MD*

## Stinging Insects

Now that spring has arrived, the stinging insects (i.e. bees, wasps, hornets and yellow jackets) are out and about. Children have a tendency to aggravate these insects through agitated movement and noise. This behavior can evoke attack and potentially lead to severe allergic reactions. If a child is allergic to bee stings, for example, she most likely will be allergic to wasp stings and other stinging insects.

There are some important differences among the stinging insects. For example, the stings of bees and other stinging insects differ because the stinger of the bee remains in the victim's skin so that bee can only sting someone once, whereas wasp and hornet stingers remain intact and they may sting multiple times.

### What Are the Signs and Symptoms of a Sting?

- Most people who are stung by an insect will have redness, itching, swelling, and some pain around the sting site as a result of the injected venom (photo available at www.kidemergencies.com).
- These signs and symptoms may increase over 24-48 hours and usually resolve in five to ten days.
- Although less common, a skin reaction to a stinging insect may occur away from the sting site and include hives, itching, and redness.
- Severe allergic reactions (anaphylaxis) may occur in some individuals after being stung by bees, wasps, or yellow jackets. A severe reaction may occur immediately or hours after a sting and may involve breathing difficulty (wheezing), swelling deep in the throat or low blood pressure.

### What Do I Do if My Child is Stung?

1. If a stinger is present, remove it as soon as possible by scraping a sharp edge (e.g., credit card) across the wound. Do not touch or squeeze the stinger. This will force venom (poison) into the skin.
2. Wash the sting site with soap and water.
3. Apply a cool compress to help stop the pain and swelling.
4. Administer an antihistamine for hives and itching but avoid using both oral forms and creams.
5. In some cases, your doctor may need to treat your child with steroids.

Individuals who know they are allergic to wasp or bee stings should carry an epinephrine (adrenalin) auto-injector (Epi-Pen) whenever they may be exposed to these insects.

- For more information on Epi-Pens see http://www.allergicchild.com/epipen_ana_medicalert.htm.
- An Epi-Pen is available by prescription from a physician.
- For a demonstration on how to use an Epi-Pen, go to http://www.allergyinatlanta.com/affiliate1/treatments/index.php.
- Your pediatrician may recommend consultation with an allergist/immunologist for evaluation and possible skin testing for fire ant hypersensitivity if your child has had a serious reaction to a fire ant sting.

### Tips to Lessen the Risk of Being Stung

1. Stay away from places where stinging insects are found, such as around flowers, garbage cans, picnic grounds, and other places food is kept.
2. Be aware of surroundings. Listen for buzzing and look for nests or hives.
3. While you are walking in grassy areas or doing yard work, wear long pants, long sleeves, a hat, gloves, and shoes.
4. Wear light-colored clothing. Dark blue and black seem to attract attack.
5. Carry protection. Use a flying insect killer with a long-range spray only when necessary, as injured insects send out pheromones that attract others to their defense. Though repellents aren't effective against bees or wasps, the continuous flow of air from an aerosol spray may confuse them, giving you time to escape.
6. Stand still when in the presence of a stinging insect. Tell kids to pretend they're statues. Rapid movement startles the insect and encourages it to sting.
7. Try blowing gently on the insect. This can encourage it to move on while not startling it.

***Continued on page 13***

# Pediatric Points

*By Carolyn Roy-Bornstein, MD*

## Dispelling Fears and Misconceptions About Vaccines

For the past ten years I have been fielding questions from parents who are concerned about a possible link between certain vaccinations and the development of autism. Even though scientific evidence at this point is very strong that there is no causal relationship, I am getting more questions now than ever. Part of the problem is that we still don't know what causes autism, its rates are still rising, and that's frightening. The Internet is both a blessing and a curse when it comes to dispensing information, and it's very difficult for parents to sort out truth from hype or sensationalism. Here are my two cents on two vaccine myths.

### Myth #1: MMR Vaccine Causes Autism

The measles-mumps-rubella – MMR – vaccine controversy began in 1998 when British gastroenterologist Dr. Andrew Wakefield described a series of 12 children with developmental regression and stomach problems. Nine of the 12 had been diagnosed with autism. Eight of the nine children's parents reported that the start of their behavioral changes coincided with the administration of the MMR vaccine at 12 to 15 months of age. This also happens to be the same age at which autistic behaviors tend to emerge. But a temporal relationship does not necessarily imply cause and effect. While Wakefield and his colleagues offered a theoretical mechanism of action, they never actually proved it. Wakefield argued that these 12 children must have been infected with the vaccine strain measles virus causing inflammation in the stomach, which allowed potential neurotoxins into the body. Wakefield and his co-authors' study was published in the British medical journal *Lancet* and caused a media frenzy. Immunization rates plummeted despite these authors never offering proof of their theory.

Since then, numerous scientific studies have failed to demonstrate a link between autism and the MMR vaccine. Some were large studies that compared rates of autism in vaccinated vs. unvaccinated children. Others noted an increase in the rates of diagnosis of autism without a similar increase in MMR administration. In Japan, where MMR vaccine coverage was suspended for a time, the rates of autistic spectrum disorders (ASD) continued to rise. One important recent study failed to detect persistent measles virus in autistic children who got their routine MMR.

The bottom line regarding the Wakefield report is that it was a very small study with very few children and that proposed a theory with no proof. Importantly, 10 of the 12 authors of that study have since published retractions of their findings. The Institute of Medicine (IOM) has concluded that, "the body of epidemiological evidence favors rejection of a causal relationship between the MMR vaccine and autism."

### Myth #2: Thimerosal Causes Brain Damage

Another recent vaccine scare involved thimerosal, which has been used as a preservative in vaccines, eye solutions and other pharmaceutical products for decades. It contains trace amounts of ethyl mercury, an organic mercury related to, but quite different from, methyl mercury, which is contained in contaminated fish such as tuna and swordfish. Methyl mercury is a known neurotoxin that readily crosses the placenta and is known to cause brain damage. (This is the reason children and pregnant women are advised to limit their consumption of certain types of seafood to two servings a week and avoid other types altogether.) Ethyl mercury, on the other hand, crosses into the brain less readily and is broken down and cleared by the body more quickly than methyl mercury.

Exposure to cumulative amounts of trace thimerosal found in vaccines has never been proven to cause any adverse effects in children. In 2001, despite the theoretical risk of adverse effects, the American Academy of Pediatrics (AAP) and the US Food and Drug Administration (FDA) urged manufacturers to remove thimerosal from vaccines as a precautionary measure and to maintain the public's trust in the vaccine program. Currently only certain types of flu shots still contain thimerosal. All the rest of the vaccines in the currently recommended schedule are thimerosal-free.

***Continued on page 13***

# Pediatric Insider

*By Roy Benaroch, MD*

## Asthma

**Q** I have a 21 month old with chronic asthma and bronchitis. What would you recommend to help treat my child? Also, what is your view on goat milk?

**A** Asthma is one of the most common chronic diseases of childhood, and has become much more common in the developed world over the past twenty years. Young children with asthma have recurring bouts of wheezing or coughing, most commonly triggered by ordinary viral colds. The usual way that these kids come to medical attention is that they develop severe or prolonged coughs or wheezing breathing when they catch a cold.

In the past, there were few good treatments for asthma, and children with asthma tended to stay sick. They spent more time indoors, and were often unable to run and play like other children. Even today, many parents and even some doctors are reluctant to say or believe that a child has asthma. Sometimes, children with asthma are said to have recurrent "bronchitis" or "reactive airways disease," but these terms should no longer be used. These days, it's important to diagnose asthma correctly so children can be treated in the best possible way. With good, state-of-the-art medical care, children with asthma should have no restrictions at all on their activities, and can be managed very well at home. Even children with severe asthma can do very well.

The first step in managing asthma well is to teach parents how to avoid triggers, and how to recognize signs of an asthma flare-up in their child. A variety of medications are very effective, including some that are taken just "as needed" and others that work best if taken every single day. You'll need to work with your pediatrician to develop a treatment plan, but once this is in place you ought to be able to keep your child healthy and well almost all of the time. Follow your doctor's instructions, and if you don't understand anything, ask. If your child continues to have problems despite the medication your pediatrician is prescribing, then ask for a referral to a specialist.

Goat's milk is great for baby goats, but really doesn't offer any advantages over cow's milk for our children. For children who are allergic to traditional milk, soy milk is a good, nutritious, and relatively inexpensive alternative for toddlers. Goat's milk is expensive, and is nutritionally inadequate – especially for the vitamin folate. Note that infants less than one year of age should be fed only commercial infant formula or breast milk (in addition to age-appropriate solids).

## Flat Heads

**Q** I am adopting a child internationally and my nine-month-old baby girl has a head that is not only flat at the back, which I understand, as the babies lay in their cribs on their backs most of the time, but also on the side. I am most concerned about the right side of her skull because it is higher than the left side by about ½-inch. When I stand above her looking down at the top of her head, the right side of her face is slightly more frontward than the left side… she has had a large bump at the base of her head where the neck connects in the back. They said she hit her head. I don't know if she has water on the brain, if it's a cranial problem, etc. Whatever you can do to help, I would so appreciate it.

**A** First, congratulations on your growing family! There are a few different causes of flattened heads, and you probably won't be able to know for sure what needs to be done until your own doctor examines your daughter. "Water on the brain" – also called "hydrocephalus" – occurs when there is a blockage to the flow of fluid around the brain. It's most commonly seen in babies who were born prematurely and had bleeding in the brain. Usually, the head grows large in hydrocephalus, but grows proportionally. If there's a flat, asymmetric area, it's probably not hydrocephalus.

More likely, she has "plagiocephaly," which is head flattening caused by the way bones grow. Most commonly it occurs when a child lays on her head in the same position for a long time. Plagiocephaly caused by external pressure does not cause brain damage, and a small degree of plagiocephaly doesn't require any therapy. In fact, almost all of us have at least a little bit of imperfection in the roundness of our heads. But if the plagiocephaly is pronounced, a fiberglass "helmet" can be custom made to help the head grow rounder. These work best if they're fitted by six months of age. Some kids with this sort of plagiocephaly have weakness in

their neck muscles, preventing good head movement. These kids should be referred for physical therapy.

Rarely, plagiocephaly can be caused by bones in the skull fusing closed too early. These babies should be urgently referred to a neurosurgeon, as a delay in treatment can lead to serious problems. Usually the physical exam will reliably indicate if this has happened, and no further tests are needed. If it's unclear if the bones have fused properly, a head CT scan may be needed.

*Roy Benaroch, MD, FAAP is an associate clinical professor of ediatrics with Emory University, and is in private practice with Pediatric Physicians, PC in Atlanta. His first book,* A Guide to Getting the Best Health Care for Your Children*, is now available. He recently start a blog at http://www.pediatricinsider.com/.*

*Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.*

# Cavities in Overweight Kids

Overweight kids are at an increased risk for many health problems, but dental cavities aren't one. A study from the Eastman Department of Dentistry, University of Rochester found that weight had no effect on rate of cavities in children two to five years old, but in children six to eighteen years old, being overweight was associated with a lower rate of cavities.

The findings surprised the researchers. According to Dorata Kopycka-Kedzierawski, DDS, MPH, the lead author, "We expected to find more oral disease in overweight children of all ages, given the similar causal factors that are generally associated with obesity and caries. Our findings raise more questions than answers. For example, are overweight children eating foods higher in fat rather than cavity-causing sugars? Are their diets similar to normal weight peers but lead more sedentary lifestyles? Research to analyze both diet and lifestyle is needed to better understand the results."

*Community Dentistry & Oral Epidemiology*, 4/08

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***Stinging Insects – continued from page 10***

8. If attacked, place your hands and forearms across your head to protect your eyes, throat and neck. Brush insects off the skin with a sideways motion. Move away quickly and quietly, as agitated movement and noise can irritate the insects and evoke further attacks.
9. Don't wear strong perfumes or cosmetics, particularly floral-scented ones, which can attract bees and wasps.
10. Don't leave opened cans of sweet drinks or beer standing around. Always check before drinking from an open container, even if it contains only water.

*Martin Belson, MD is a pediatric emergency medicine physician at Children's Healthcare of Atlanta at Scottish Rite, a medical toxicologist, creator/editor of www.kidemergencies.com and host of the Pediatric Health Hour every Wednesday at 9AM on www.radiosandysprings.com. He is also the author of www.kidemergencies.com, a user-friendly, free resource on children's health emergencies and poisonings for everyday mothers and fathers.*

***Vaccines – continued from page 11***

Since then, numerous studies have not demonstrated a higher incidence of autism or ASD in children vaccinated with thimerosal-containing vaccine compared with children vaccinated with the thimerosal-free version. Other studies found that the rates of autism continue to rise even though thimerosal has been removed from childhood vaccines. Again, the IOM concluded that the evidence favors rejection of a causal relationship between thimerosal-containing vaccines and autism.

## Let's Keep Vaccine Myths in Perspective

We all want to protect our children from disease while keeping them safe from harm. At this point it seems clear that the benefits of vaccination against real disease far outweigh any risks. There has been a greater than 99% decrease in the reported incidence of measles since the measles vaccine was first licensed in 1963. But measles is still around and it is a nasty disease. Acute measles encephalitis, which often results in permanent brain damage, occurs in one of every 1,000 cases; death occurs in one to three of every 1,000 here in the U.S.

It is clear that we still don't know what causes autism, but the question about the role of vaccines in its development has been answered and research dollars should be spent looking elsewhere.

*Carolyn Roy-Bornstein is a board certified pediatrician in private practice in Haverhill, MA.*

# Watch Your Mouth!

*By Giusy Romano-Clarke, MD*

Dental decay is the single most common chronic disease of childhood. It is caused by a bacterial infection in the mouth and occurs five-times more often in children than asthma. As a pediatrician, I see children every day who live with untreated dental decay. Despite the centuries of advances we have made in medicine and public health right here in Massachusetts, nearly half of all children in our state have experienced dental decay by the time they reach third grade.

Dental decay can profoundly impair a child's ability to eat, sleep and concentrate. Recent connections discovered between oral health and pancreatic cancer add to the mountain of evidence showing the strong link between dental disease and poor health outcomes. These connections follow us through the lifespan, with associations to heart disease, lung disease, diabetes and the delivery of pre-term, low-birthweight babies. As with many diseases, children with dental decay most often grow up to be adults with dental decay.

The good news is that dental decay is preventable. We have some tried and true commonsense solutions to what the U.S. Surgeon General has called the nation's silent epidemic. Together we can ensure that children have access to care and prevention.

## Oral Health and School Readiness

We all know that healthy kids learn better. Children who have untreated decay have trouble eating, sleeping and paying attention in school. In fact, nationally 51 million school hours are lost each year due to dental decay. To ensure that our children have every opportunity afforded to them, we need to make preventive treatment available in the places where they spend their days – in schools, preschools, and community-based settings.

To ensure that kids get off to a healthy start, we must work together to implement local solutions. When schools and parent-teacher organizations make in-school screenings, sealants and fluoride treatments available during the day, kids stay in school and continue to progress.

## Prevention

The Watch Your Mouth campaign identifies three major areas of prevention: dental sealants, fluoride treatments, and oral screenings.

A dental sealant is a thin plastic coating that is professionally applied to the surfaces of molar teeth to prevent cavities. Sealants benefit children and young teens because they provide a physical barrier that keeps bacteria from infecting the pits and grooves on the chewing surfaces of teeth. This important preventive measure can be offered through school-based and community health settings and in dental offices.

Fluoride occurs naturally and can help prevent dental decay by strengthening the teeth and making them more decay resistant. Fluoride treatments come in the form of community water, toothpaste, gels, varnish, and mouth rinses. Sealants, along with consistent exposure to fluoride, can prevent the majority of tooth decay in children.

Community water fluoridation is a safe and effective preventive measure. Levels of fluoride can easily be adjusted in community water supplies. Fluoride keeps tooth enamel strong and prevents tooth decay and the serious problems that occur with dental infections. With an average cost of $.50 per person per year, water fluoridation also saves millions in dental treatment and insurance costs.

Pediatricians and family physicians can play an active role in oral disease prevention. New pediatric models of care address early childhood dental decay in states like Massachusetts, Washington, North Carolina and New Hampshire. For instance, the Healthy Teeth for Tots program in Boston, MA calls for oral health education and the application of fluoride varnish to children's teeth at well-child visits during the first three years of life. Applying fluoride varnishes to children's teeth prevents tooth decay and reverses early disease. A program like Healthy Teeth for Tots indicates that the medical profession is moving closer to bridging the artificial gap between general health and oral health and is giving children's mouths the care they deserve.

To protect the health of the next generation, we must work together to ensure that children have access to preventive care in their communities.

*Dr. Giusy Romano-Clarke is a pediatrician and director of Healthy Teeth for Tots, a pediatric oral health program located at Dorchester House Multi-Service Center in Dorchester, MA. She is also a member of the Watch Your Mouth coalition.*

# Lack of Sleep Among Seven Year Olds

*By Ed Mitchell, MD*

An adequate amount of sleep is important for optimal health and well being throughout life. In adults, sleep restriction is associated with poor mental function and mood disturbances, as well as with obesity and raised blood pressure. There have been few studies of sleep duration in children, and these have mostly focused on children attending clinics. Most other studies have relied on parental reports of their child's sleep duration.

A recent study from New Zealand reported in the medical journal *Sleep* described the factors affecting sleep duration in 7-year-old children. The study focused on 591 seven year olds whose sleep duration and physical activity were assessed objectively by actigraphy (a non-invasive method used to study sleep-wake patterns and circadian rhythms by assessing movement). These children had been followed at various ages since birth.

The average sleep duration was 10.1 hours, but the amount varied considerably, with the majority getting between 8 and 12 hours of sleep. The study found that sleep duration was:

- 41 minutes shorter in summer compared with winter
- 31 minutes shorter on weekends than weekdays
- 12 minutes shorter if the child had a younger brother or sister, and
- 41 minutes shorter if bedtime was after 9:00 pm.

Many parents would have experienced difficulty with getting children to go to sleep on summer nights when it remains light outside, but the size of the effect was unexpected. Seven year olds go to bed later on weekends but still wake at the same time, thus shortening the time asleep. This contrasts with adolescents who typically go to bed late, but wake up even later, so they often have more sleep on weekends than during the week.

Children who slept less than nine hours were more likely to be overweight or obese and to have a 3.34 percent increase in body fat than those who slept for more than nine hours. There was a three-fold increased risk of the child being overweight or obese. This effect was independent of physical activity or television watching. Attention to sleep in childhood may be an important strategy to reduce the obesity epidemic.

Short sleep duration was also associated with higher emotional liability scores. However, there was no association found between sleep duration and intelligence or ADHD.

The American Academy of Sleep Medicine (AASM) offers some tips to help your child sleep better:

- Follow a consistent bedtime routine. Set aside 10 to 30 minutes to get your child ready to go to sleep each night.
- Establish a relaxing setting at bedtime.
- Interact with your child at bedtime. Don't let the TV, computer or video games take your place. Read a story together.
- Keep your children from TV programs, movies, and video games that are not right for their age.
- Do not let your child fall asleep while being held, rocked, fed a bottle, or while nursing.
- At bedtime, do not allow your child to have foods or drinks that contain caffeine. This includes chocolate and sodas. Try not to give him or her any medicine that has a stimulant at bedtime. This includes cough medicines and decongestants.

Parents who suspect that their child might suffer from a sleep disorder are encouraged to consult with their child's pediatrician or a sleep specialist.

*Dr Ed Mitchell is a pediatrician from Auckland, New Zealand. He trained at St George's Hospital Medical School in London and has worked in the UK, Zambia and New Zealand. His clinical work is in developmental paediatrics. Since 2001, he has been the professor of child health research at the University of Auckland.*

# Seasonal Variations in Vision

People born in June and July are more likely to be myopic (near-sighted) than those born in December and January. This is result of a study of 277,000 Israeli military recruits who were born and grew up in Israel. No one knows why a seasonal influence exists since genetic factors are the single strongest factor in predicting vision problems. Scientists postulate that the influence of light on vision may occur through mother-baby biological signals before birth, through the baby's direct exposure to light after birth, or both.

*Ophthalmology*, 4/08

# A Few Words from the Editor

I am pleased to welcome two new regular contributors – Drs. Belson and Roy-Bornstein. Both are experienced pediatricians and want to share their knowledge with you.

Dr. Belson works in a pediatric emergency room. His writing reflects his unique perspective – treating kids when they are sick enough to be seen in the emergency room. It can be a stressful time for everyone involved.

Among his other activities, he runs his own website – *www.kidemergencies.com.* It an excellent site and one you should check.

Dr. Carolyn Roy-Bornstein has many years of experience in both primary care pediatrics and pediatric emergency care. Her writing on pediatric topics appears in a local newspaper.

Dr. Roy Benaroch has taken over the question and answer column. He has also started a new blog. You can check it out at *www.pediatricinsider.com.*

Please keep sending your questions and column ideas. We read them all and they help us produce a better newsletter.

*Rich Sagall, MD*

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Richard J. Sagall, MD, Editor
(richsagall@pedsforparents.com)
Vikki Sloviter, Staff Writer
and Proofreader
(vikki@pedsforparents.com)

Writers' and submission guidelines are available on our website: www.pedsforparents.com. Please send a query before submitting articles.

Editorial, business, subscription and advertising office:
***Pediatrics for Parents***
PO Box 219.
Gloucester, MA 01931

E-mail:
info@pedsforparents.com.

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